THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.2212a Policy or certificate issued under chapter 34 or 36; description of terms, conditions, and information; written request; "board certified" defined.

Sec. 2212a. (1) An insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical policy or certificate issued under chapter 34 or 36 shall provide a written form in plain English to insureds upon enrollment that describes the terms and conditions of the insurer's policies and certificates. The form shall provide a clear, complete, and accurate description of all of the following, as applicable:

(a) The service area.

(b) Covered benefits, including prescription drug coverage, with specifications regarding requirements for the use of generic drugs.

(c) Emergency health coverages and benefits.

(d) Out-of-area coverages and benefits.

(e) An explanation of the insured's financial responsibility for copayments, deductibles, and any other out-of-pocket expenses.

(f) Provision for continuity of treatment if a provider's participation terminates during the course of an insured person's treatment by that provider.

(g) The telephone number to call to receive information concerning grievance procedures.

(h) How the covered benefits apply in the evaluation and treatment of pain.

(i) A summary listing of the information available pursuant to subsection (2).

(2) An insurer shall provide upon request to insureds covered under a policy or certificate issued under section 3405 or 3631 a clear, complete, and accurate description of any of the following information that has been requested:

(a) The current provider network in the policy or certificate's service area, including names and locations of participating providers by specialty or type of practice, a statement of limitations of accessibility and referrals to specialists, and a disclosure of which providers will not accept new subscribers.

(b) The professional credentials of participating health professionals, including, but not limited to, participating health professionals who are board certified in the specialty of pain medicine and the evaluation and treatment of pain and have reported that certification to the insurer, including all of the following:

(*i*) Relevant professional degrees.

(*ii*) Date of certification by the applicable nationally recognized boards and other professional bodies.

(*iii*) The names of licensed facilities on the provider panel where the health professional presently has privileges for the treatment, illness, or procedure that is the subject of the request.

(c) The licensing verification telephone number for the Michigan department of consumer and industry services that can be accessed for information as to whether any disciplinary actions or open formal complaints have been taken or filed against a health care provider in the immediately preceding 3 years.

(d) Any prior authorization requirements and any limitations, restrictions, or exclusions, including, but not limited to, drug formulary limitations and restrictions by category of service, benefit, and provider, and, if applicable, by specific service, benefit, or type of drug.

(e) Indication of the financial relationships between the insurer and any closed provider panel including all of the following as applicable:

(*i*) Whether a fee-for-service arrangement exists, under which the provider is paid a specified amount for each covered service rendered to the participant.

(*ii*) Whether a capitation arrangement exists, under which a fixed amount is paid to the provider for all covered services that are or may be rendered to each covered individual or family.

(*iii*) Whether payments to providers are made based on standards relating to cost, quality, or patient satisfaction.

(f) A telephone number and address to obtain from the insurer additional information concerning the items described in subdivisions (a) to (e).

(3) Upon request, any of the information provided under subsection (2) shall be provided in writing. An insurer may require that a request under subsection (2) be submitted in writing.

(4) As used in this section, "board certified" means certified to practice in a particular medical or other health professional specialty by the American board of medical specialties or another appropriate national health professional organization.

History: Add. 1996, Act 517, Eff. Oct. 1, 1997;—Am. 1998, Act 424, Eff. Apr. 1, 1999;—Am. 2001, Act 235, Imd. Eff. Jan. 3, 2002.

Compiler's note: Enacting section 1 of Act 235 of 2001 provides:

"Enacting section 1. The 2001 amendatory act that added section 2212a(4) to the insurance code of 1956, 1956 PA 218, MCL 500.2212a, shall not be construed as creating a new mandated benefit for any coverages issued under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302."

Popular name: Act 218